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ABSTRACT

The paper explores the relationship between 330 families' adaptations to their mentally retarded children and the manner in which parents plan for future residential and vocational opportunities. B. Farber's theory of minimal family adaptation is tested to see whether family characteristics (such as demographics and family career); child's characteristics (such as severity of the disability, sex, and age); and the family's involvement in informal and formal social networks affects parents' planning. A literature review applies the concepts of family career and individual life cycles to families with mentaly retarded children as they plan for future services. Forward stepwise regression analyses were performed on data gathered from a mail survey questionnaire of 330 parents of mentally retarded children from birth to 21 years old. In general, strong support was found for Farber's theory of minimal adaptation. The strongest predictors of parents' planning were family career, child's characteristics, and community support. Family demographics were found to be the least significant predictors. (Author)

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# A Family Career and Individual Life Cycle Perspective on Planning Residential and Vocational Options for Mentally Retarded Children*

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## INTRODUCTION

Socialization and education of children within the family and the school are structured to develop children's skills and competencies in accordance with anticipated outcomes. As individuals reach adulthood they are expected to leave the family of orientation to form their own families and forge their own careers. Parents' idealized goals for their children are modified by family circumstances and individual differences. Not all children can or want to go to college--let along Harvard, marry or become white collar professionals. But it is normative for young adults to leave home, to become autonomous, and to make their own decisions. Such normative expectations cannot simply be assumed for mentally retarded young adults. Parents have continuing responsibility for planning their children's futures.

Families with mentally retarded children have been the subjects of sociological research since Tizard and Grad's (1961) study of families in Great Britain during the 1950's. Almost concurrently, the study of families with mentally retarded children in the United States was begun by Farber (1968). Each study spawned different lines of research (Rowitz, 1974). Western European studies following Tizard and Grad (1961) were products of National Health services and therefore oriented towards understanding the different types of persons who utilize government-provided services. Thus research was used to provide information on the characteristics of persons and their families and the services they use.

Farber (1968) was concerned with families' adaptations to having a mentally retarded child. Rowitz (1974) relates that Farber developed a

conceptual model "to define different types of family organization which affect marital integration and severity of family crisis for parents of (mentally) retarded children."

The present study combines these two perspectives by using Farber's conceptual model of family adaptations as applied to a specific service utilization situation--parents' planning for future residential and vocational service use by their mentally retarded children. A developmental framework combines individual life cycle stages and family careers as variables measuring family adaptations to mentally retarded children. The idea was suggested by Birenbaum's (1971) application of Farber's theory in the study of mentally retarded children in the home and family life cycle. The basic premise is that predictable changes in the life course of individuals and families can be used to understand characteristics of service use and plans for future service use by families with mentally retarded children.

In addition, the present study also builds in the concept of social embededness because decision-making by parents does not take place in the vacuum of the nuclear family unit. Personal and community support systems are resources that families use to live their everyday lives. Parents' decision-making, therefore, occurs within consideration of these community networks.

Normative Family Career Development

Predictable changes in the life course of the family form the bases for stages in the family career. A stage is a division in the family career that is distinctive enough from periods that come before and after

it to make it analytically distinctive (Aldous, 1978:81-86). Duvall and Hill's (1948) stage classification for the analysis of nuclear family careers includes: (1) Newly Established Couple, (2) Childbearing, (3) Families with School Children, (4) Families with Secondary School Children, (5) Families with Young Adults, (6) Families in the Middle Years, and (7) Aging Families.

Those stages most pertinent to this study are 4 and 5, families with secondary school children and families with young adults. In stage 4, adolescents are beginning to press for more independence in anticipation of leaving their family of orientation. While first described as a period of storm and stress by Hall (1904) and often characterized as such by others, the "generation gap" between parents and adolescents has been shown to be less stormy and stressful where parents anticipate their adolescents' entry into adult roles and actually prepare them for it. Parental relinquishing of control and adolescent acquisition of responsibility do not, however, proceed at a steady rate in all areas. Parents and adolescents maintain stable arrangements in some areas in order to facilitate the changes that take place in other areas (Aldous, 1978:264). The attainment of adolescence for children in the nuclear family coincides with a time of relative economic need by parents who are in their forties or early fifties. Except in the case of high level professionals, managers and sales occupations, average earnings for families have peaked at an earlier time period, therefore earnings are at that time somewhat less. As a consequence, these families run a risk of deterioration in their standard of living unless additional income is obtained (Oppenheimer, 1974).

In stage 5, parents and their young adult children try to reform relationships in order to relate to each other as adults rather than as parents and children (Levinson, et al., 1978:23). Parents experience a chance to reformulate their relationships with their spouses as their parental responsibilities decrease and the last children leave home to establish their own families of procreation.

Normative Individual Life Cycle Stages

The interaction of biological and environmental factors within a developmental perspective forms the basis of the study of life cycle stages. Physical, cognitive, emotional, and social development in humans seem to take place in an orderly fashion where certain achievements or steps need to be taken before others in order for normal development to continue. The association between age and developmental achievements or stages is not strictly spelled out. Due to the stronger association of developmental stages and age ranges, life cycle stages have been assigned to age ranges by many researchers to suit the needs of their studies (see, for example, Havighurst, 1952; Rosow, 1974; Elder, 1975; Erikson, 1963; Piaget in Ginsburg and Opper, 1969; Levinson, et al., 1978). Each, however, posits the necessity of accomplishing certain tasks within one stage before moving successfully on to the next.

Biological development stages have included adolescence or pubescence as the final stage in the physical development of humans. Though not as well studied as the earlier stages where biological development takes place at a much more rapid pace (Chinn, Drew and Logan, 1979:286) research shows that there is a systematic though not uniform development in adolescence which culminates in sexual maturity and attainment of

final growth (LeFrancois, 1976:37-53).

Developmental psychology adds the notion of "critical periods"--certain periods when optimal growth and organization of a behavior system can be most easily affected (Fitzgerald, Strommer and McKinney, 1977:5) --to the notion of life cycle stages. If the developmental tasks which arise at or about a certain period in the individual's life are not successfully achieved during that period later development becomes more difficult (Havighurst, 1952; Levinson, et al., 1978; Vaillant, 1977).

Applicability of the Family Careers and Individual Life Cycle Perspectives to Families with Mentally Retarded Children

The previous discussion has dealt with the study of human development from the family career and life cycle stages perspectives for typical families and persons in our society. Mentally retarded children, however, do not progress as quickly through their life cycle stages, thereby restricting the development of their families' careers. Mentally retarded children and their families are, therefore, exceptions to the perspectives discussed above. They represent a special area of study within these two perspectives, which may also include other families who have members with disabling conditions [such as sick children (Burton, 1975; Travis, 1976), mentally ill children (Park and Shapiro, 1976; Shepherd, Oppenheim and Mitchell, 1966) and children with physical handicaps (McMichael, 1971; Ayrault, 1971)]. Although no such study has been conducted, Farber (1975) has proposed a theoretical model by which the adaptation of these families could be studied.

Farber has developed the theory that families make as minimal an adaptation as possible to solve problems involving family relationships.

He defines adaptation to be any sustained change in roles, norms, or family interaction which family members make (individually or collectively) with the intention of effectively handling (by either solving or living with) the offensive situation. The minimal adaptation assumption implies a temporal progression of adaptations from the simple to the complex, from the least disruptive to the potentially fully disruptive. Hypothetically, all things equal, families start out with the most minimal adaptations to their problems and proceed to successively more extensive and drastic ones only when the simpler adaptations are not effective.

Farber goes on to directly apply his theory of minimal adaptation to families with mentally retarded children. The continued presence of a severely mentally retarded child in the home represents a dynamic set of problems rather than a static problem. Even in so called normal families, relationships are under continual pressure to change. This inherent instability derives from the fact that age-sex roles vary with movement in the family life cycle. As both children and parents age, role expectations are modified. The mentally retarded child does not, however, develop fast enough or far enough to allow the family career to continue as one would expect. Farber proposes that there is an arrest in the family career. While normal children's statuses, roles, and role expectations in the family change as children get older, mentally retarded children fail to meet the cognitive, psychological, and social expectations that their physical development engenders.

It is precisely the identification of the child as mentally retarded which sets in motion the process of adaptation by the family to the condition of the disabled member. The interaction of two factors

--the maximum potential adaptive behavior of the disabled member and the economic, social and psychological resources of the family--determines to what extent adaptations will be made in order for the family to cope with its disabled member yet still remain a group, fulfilling various family tasks and socialization functions. The varieties of adaptation form a continuum along which family career and life cycle stages for the mentally retarded can be studied. Parents of all but the most severely handicapped children or those with extenuating home situations usually have no choice but to keep their children at home and attempt to provide their children with as normal a home life as possible.

The differences between mentally retarded children and others become more pronounced as the children grow older. As children grow up, persons in the community expect behaviors and acts to coincide with age and size. Behaviors which are considered 'cute' when children are small are inappropriate for older children (Suelzle and Keenan, 1979:29; Birenbaum, 1971). Physically, mentally retarded adolescents mature at about the same time or slightly later than other adolescents (Hall, 1974: 186). While their sexual and physical maturation are nearly the same as other children, cognitive, psychological and social development are far behind normal adolescent development. The differences between physical size and the social, cognitive and emotional skills of the mentally retarded adolescent are painfully evident to adolescents and their families. Mentally retarded adolescents face the same psychological challenges as normal adolescents, yet their cognitive capacities are less than those of normal adolescents. They, too, must resolve the identity versus role confusion tasks (Erikson, 1963), but may have neither the capacity nor

the opportunity to successfully accomplish it. Studies show that the mentally retarded are aware of their sexuality and strive for independence in much the same manner normal adolescents do (Morgenstern, 1973; Edmonson, McCombs and Wish, 1979).

Families with mentally retarded children have, by this time, well established patterns of adaptation. Education provided through the school system aids families with coping with their children. Since the children attend and progress through special classes in much the same manner (but not, of course, at the same speed or content) that normal children do, a familiar routine has been established that approximates that of other children. Social roles in the family are being strained, however, because mentally retarded children do not take on responsibilities commensurate with age, and therefore still demand the attention that much younger children would demand. The mentally retarded adolescent with siblings will have moved to the status of youngest child because the level of family tasks performed and responsibilities taken is much less than that of younger siblings (Farber, 1968:158). An incongruency exists in adolescence for mentally retarded persons. Their roles in the family have stagnated at a childhood level yet the challenges of adolescence, which with ample opportunity can be accomplished, demand increased independence in order to bring them to a positive resolution.

The schools with their special education classes and supportive services have provided the opportunities for adolescent development to begin. The end of formal education and the subsequent dearth of a comprehensive coordinated service system for disabled adults blocks the resolution of

adolescent development and arrests family career development completely, causing families, once again, to begin to significantly readjust their roles to the changing needs of their disabled members. Mentally retarded young adults are unable to begin the adult life course as described by Levinson et al. (1978) because almost any measure of independence from the family of orientation is not possible due to the lack of adequate services to support the transition (Rowitz, 1975:10).

Parents' Planning Within the Context of Community Networks

The planning and organizing of services are as important as the prevention and treatment services. Difficulties experienced by parents, their mentally retarded children, and concerned practitioners often stem from lack of services to complement existing services, duplication that strains service resources at a time when fiscal restraint is in vogue, and a lack of jurisdiction for service delivery. The organization and delivery of services should allow for an orderly progression through family career and life cycle stages and each of the service elements should be consistent and integrated (Sellin, 1979:212, 238).

Planning exists within "a continually changing system of values which identifies social preferences at any particular point in time" (Kurtz, 1977:135). Parents face a society that does not change easily, that is "crisis-oriented and reaction-motivated" (Begab, 1975:4). Parents face a scenario in which societal interest in particular social problems waxes and wanes with successive "crises" (Albrecht, 1976:258-260). Parents planning in the late 1970's reflected the "tax-cutting" mood of the country.

Planning for services to persons with mental retardation has changed

dramatically over the past twenty-five years. Community services in the 1950's were being developed by private interests, usually parent associations. They were set up independently in hundreds of different localities around the United States without any concerted hierarchical planning by state or federal government (Katz, 1961). As the parent associations successfully lobbied for the provision of community services through public institutions, such as local or state educational agencies, planning of these services became formalized, with administration being done by professionals. State and federal agencies developed planning departments to plan for future services. Professionals, with more in-depth knowledge became the "experts" and parents were excluded from the planning process. With the passage of P.L. 94-142, The Education for All Handicapped Children Act, parents were formally made partners in the planning process of their children's curricula. This role of partner has been encouraged by a few (such as Biklen, 1974, and Hobbs, 1975:229) so that parents would be involved in the planning process at all levels, for all services, over their children's entire life cycle.

The concepts of normalization and deinstitutionalization reflect the ideology of a community-based service system for the mentally retarded. The philosophy of normalization simply stated says that the lives of mentally retarded persons should be as normal as possible (Nirje, 1976:364-367). The application of the normalization philosophy had different nomenclature in different societal institutions. For residential services to mentally retarded persons the word "deinstitutionalization" was coined to describe the change in orientation from institutional-based services to community-based services. For educational

services, the word "mainstreaming" is used to indicate the provision of educational services in the least restrictive setting.

Unfortunately, as Begab (1975:26) points out, "normalization is more a philosophy of human rights than a prescription for treatment." The community-based services have helped families with mentally retarded children to approximate normality (Birenbaum, 1971:56), but this may be only a temporary phenomenon due to the extensive support provided by the educational system. The lack of community support for services to mentally retarded adults shows up in institutional admissions data. Scheerenberger (1976:85-86, 170, 171) found that while some data seem to support deinstitutionalization (for example, the significant decrease since 1964 in the number of residents less than 21 years and the reduction of mild and moderates as a percentage of all institutionalized); others indicate that many problems remain. For example, there has been a significant increase in the number of residents 21 years of age or older since 1964 and many of these adults are less seriously affected and theoretically should not need institutionalization. He concludes that community programs are not being developed as extensively as necessary, and that the data also dispell the commonly-held belief that new admissions are limited to the very young and serverely retarded. What seems to be the trend is that institutionalization is being postponed from early childhood and adolescence until young adulthood. While support is provided for families during their children's early years, mentally retarded children are ill-prepared to become mentally retarded adults (Burton, 1976:191).

Studies of mentally retarded adults in the community seem to bear

this out. Edgerton's (1967:208) seminal work found that many deinstitutionalized midly handicapped adults had a difficult time adjusting to community living, because of the stigma attached to their disability, and that their efforts and capacities to deal with the stigma attached were limited. Edgerton and Bercovici's follow-up (1976) of this same group more than ten years later found that many had improved their life circumstances but in a number of cases, original predications of the direction and nature of their community adjustment proved to be inaccurate. Individual social adjustments fluctuated greatly over time making prognostication difficult.

Birenbaum and Seiffer (1976) and Birenbaum and Re's (1979) longitudinal studies of deinstitutionalized mentally retarded adults found them to be steadily involved in sheltered workshops and have some peer relationships but less involved in community leisure activities and personal decision-making than was expected. They conclude that there is no sequence of moving from dependency to self-reliance in community residence. Community-based residence and easy access to mass transportation cannot by themselves provide greater participation in leisure time activities in the community.

Mainstreaming and deinstitutionalization have not provided the means for mentally retarded adults to participate fully within the community and it is not likely that they will be able to in the near future. High unemployment rates make it more difficult for them to find jobs and become more independent and self-sufficient (Wing and Olson, 1979:178). The idea of community-based services must be realistically tempered to reflect social and economic constraints in the society. Just because a

service is being provided in the community does not make it qualitatively better than services provided in a day or residential unit of an institution. Very often the limiting factor is not the location of the service but the severity of the persons' disabilities (Wing and Olson, 1979:176) and the quality of the staff (Hobbs, 1975:201-202). Instead of focusing on location of services, more can be gained by linking services to a network which can support mentally retarded adults in the same manner as the educational and auxilary services support mentally retard children and their families.

## HYPOTHESES

The purpose of this study is to investigate factors which influence parents' planning for future services for their mentally retarded children. Since parents have primary responsibility for these children throughout their lifetimes, planning services for mentally retarded adults is dependent upon understanding parents' attitudes and hopes for the future. The hypotheses which follow are summarized in Table 1 and their specific predicted relationships are discussed below.

Table 1 about here

### Parents' Planning

Planning for future services involves choices for residential and occupational opportunities, when their children make the transition from adolescence to adulthood. It can be measured by examining parents' intentions to secure future residential care for their children and by identifying parents' projected occupational and residential settings for

their children at age twenty-one.

The Independent Variables

Farber's theory of minimal adaptation (1975) provides a framework for examining variations in parents' planning. He hypothesizes that families will make as minimal an adaptation as possible in order to solve problems involving family relationships. In the case of families with mentally retarded members, he hypothesizes that adaptations will vary according to the amount of time and energy demanded by the mentally retarded children, the extent of family resources, and prior loyalties and commitments. In the same manner, we hypothesize that parents will plan for future services according to the amounts and kinds of resources families are able to bring to bear on problems caused by having mentally retarded members. Variations within parents' planning may be explained through studying families as nuclear units within a vast community network, as suggested by Rowitz (1974). In this study, independent variables focus on families' personal and primary resources as a starting point for examining families within the whole community service system.

Family Demographics

Family resources can be measured by looking at standard family demographics, such as socioeconomic status, family composition and availability of extended family. Farber (1968:154, 197; 1975:259) predicts that the higher the socioeconomic status of families the greater will be the discrepancies between families' social and economic expectations for children and the mentally retarded children's abilities to meet those expectations. The greater emotional impact for higher socioeconomic families means they

will be more likely to extrude mentally retarded children. Therefore, we predict that families with higher incomes, white families, and more highly educated parents will be more likely to plan for more restricted residential and vocational settings.

We assume that families' abilities to cope with their mentally retarded children are enhanced when parents are currently married and at least one grandparent is living. The more adults there are involved in the families, the better able families are to cope. Therefore, we predict that families with at least one grandparent living and where the parents are currently married will be less likely to have planned future residential placement for their children or to plan for a more restricted residential setting at age twenty-one. Conversely, in the same families, parents will be more likely to plan for more sheltered work environments at age twenty-one because they will be able to support their children as dependent adults.

Parents planning for future services will be greatly affected if their children are already institutionalized. Since the literature has not focused on mentally retarded children who remain at home, predictions need to be drawn from the literature on institutionalization and deinstitutionalization and applied to the case of children at home.

The Carvers (1972:119-130) discuss the readjustment to more "normal" roles in families where mentally retarded children have been institutionalized. The readjustment process acts to normalize relationships within the family which had previously been strained. As Mercer (1966) and Birenbaum and Seiffer (1976) point out, these families may resist the deinstitutionalization of their children. Therefore, we predict that

families with mentally retarded children at home will be less likely to plan for more restricted residential and vocational settings.

Family Career

Family resources can also be measured by the concept of the family career. Roles of family members tend to be qualitatively different at each stage of the family career. For families with mentally retarded children the inability of mentally retarded members to assume different roles in progressive stages can bring families' careers to a halt (Birenbaum, 1971). We assume that this arrest in family development causes strains within the family, especially with mothers' personal lives and in husband-wife relations.

Baroff (1974:23), Ayrault (1971:165), Adams (1972:115) and Birenbaum and Seiffer (1976:75) discuss the process whereby aging parents realize their own mortality and consequently become quite anxious about their children's futures. Therefore, we predict that older parents will be more likely to plan for more restricted residential and vocational settings.

Even with "normal" families (Aldous, 1978:275) and families whose children had physical disabilities only (Ayrault, 1971:65) stresses in parent-child relations feed back into husband-wife relations. For families with mentally retarded children stress in coping with the children can lead to their extrusion from the family (Tizard and Grad, 1961:88; Mercer, 1966; Farber, 1968:194; Birenbaum, 1971:52, 62; Rutter, 1971:207). Nirje (1976:369) and Rutter (1971:207) believe that the more normalized families' situations are, the easier it is for parents to

take advantage of community services to benefit their children. We predict that parents of mentally retarded children experiencing more stress individually and in their relationships with their spouses will be more likely to plan for more restricted residential and vocational settings.

Community Involvement and Advocacy

The study of decision-making of families with mentally retarded children has to be seen as part of a community network (Rowitz, 1974:411). Personal and community supports, informal and formal groups, are resources that families use to cope and arrive at solutions about how to maintain lives (Mechanic, 1980:108, 110).

We predict that parents who perceive their neighbors as accepting their children in a variety of social situations throughout their children's life cycles will be less likely to plan more restricted residential and vocational opportunities.

Parents who consult friends and family frequently for advice about their mentally retarded children are predicted to be likely to plan more restricted residential and vocational opportunities. We are assuming that the content of advice from family and friends would be more traditional than that of school personnel.

Parents active in advocacy groups or parents' groups and governing boards have tended to be middle-class, white, and to be parents of children who are more severely handicapped (Katz, 1961). Karnes, Zehrbach and Teska (1977:38) found that the more parents are involved in programs, the higher their expectations for those programs were. Therefore, we predict that parents who are more politically active will be influenced

by the vested interests of that white, middle-class group. That is, we predict parents who are more politically active will make plans for more restricted residential and vocational opportunities.

Child's Characteristics

The lack of skills necessary to cope with modern society exacerbates people's problems in assuming ordinary social roles (Mechanic, 1980:113). For families with mentally retarded children, the nature of the children's handicaps is the most important factor causing problems within the family (Wing and Gold, 1979:106). The more severe the disability, the more likely parents are to extrude the child from the family (Carver and Carver, 1972:53; Farber, 1968:162; Mercer, 1966). In families where the children's motor skills and social skills are more impaired, parents will be more likely to plan for more restricted residential and occupational opportunities.

Farber (1968:157) found that mentally retarded males seem to create greater stresses for their families than do females. Therefore, we predict that parents of mentally retarded males will be more likely to have secured a future residential setting and to plan more restricted residential opportunities. Bayley (1973:154-157) found in a community study of severely subnormal adults that slightly more males than females were employed in the open market. Therefore, we predict that parents of mentally retarded males will be more likely to plan less restricted occupational opportunities.

As mentally retarded children grow older, the differences increase between them and other children of the same chronological age. Parents

realize that their mentally retarded children will not catch up, and parents adjust their expectations (Birenbaum, 1971:16). We predict the older the mentally retarded child, the more likely parents are to plan more restricted residential and vocational opportunities.

Extended Family

More meaningful measures of extended family resources than merely grandparent availability (that is, whether at least one grandparent is alive or not) are measures of the type of support grandparents give. In this study two conceptually distinct measures of grandparents' support are provided. Grandparents' acceptance of their mentally retarded grandchildren assesses grandparents' acceptance of the children as if they were "normal" children. Grandparents' support of parents measures grandparents' support of the parents' style of childrearing, realizing the limitations of the children.

We predict that in families where grandparents accept their mentally retarded grandchildren (that is, accept the children as if they were "normal"), parents will be less likely to plan for more restricted residential and occupational opportunities.

For families where grandparents support the parents (accepting the children's limitations), parents will be more likely to plan more restricted residential and vocational opportunities.

## DATA COLLECTION METHODS

Sampling Procedures

The sampling population was defined as Lake County, Illinois, parents

of developmentally disabled children aged 0 to 21 years who received services in Lake County. Developmentally disabled was defined as children handicapped by mental retardation, cerebral palsy, epilepsy, autism, or multiple handicaps involving one of these disorders, and whose handicap required more than 50 percent time in a special education program. All the children in the study had severe enough forms of mental retardation that they would not be classified in the mild or educable range of mental retardation.

Data-Collection Procedure

We used a computerized review of the literature and open-ended depth interviews with parents to construct a pretested 57-page mail survey questionnaire. Structured closed-ended questions were designed to provide data regarding: (a) the manner in which parents first discovered that their child was developmentally disabled; (b) availability of extended family and community support networks; (c) the severity of the disability; (d) the manner in which parents secured community services; (e) professionals utilized; (f) attitudes regarding direct services; (g) involvement in children's educational programs and parents' organizations; (h) opinions about public policy; and (i) long-term plans and objectives for their children.

Because of adherence to regulations governing rights of privacy, we sent consent forms to 751 identified families through the educational facilities serving the county. After a follow-up mailing to increase consents, questionnaires were mailed out over the 3-month period from mid-March to mid-June 1978 to the 458 families (61.0 percent) who con-

sented to participate. Quality-control procedures to ensure respondent anonymity were used. A follow-up mailing resulted in the return of 330 completed questionnaires (43.9 percent of the families identified and contacted, 72.1 percent of the families who consented to participate).

Returned questionnaires were coded and keypunched and a file defined for statistical analysis of the data with the Statistical Package for the Social Sciences (SPSS) system of computer programs. The data were verified by eliminating out-of-range errors and performing a series of contingency checks.

Characteristics of Parents and their Children

The area of Lake County was selected for the research population because: (a) it is geographically compact, yet includes urban, suburban, and rural populations; (b) it offers a wide variety of services for mentally retarded persons; (c) providers and consumers of services to retarded persons have a history of cooperation with past efforts to secure related information; and (d) the county contains people of a wide range of socioeconomic, ethnic, and racial backgrounds.

Although the questionnaires were mailed to both parents in two-parent families, almost all were completed by mothers. Of these mothers, 20 percent had not completed high school, 33 percent were high school graduates, 31 percent had some college or special career training, and 16 percent were college graduates. In 1978 dollars, 33 percent had yearly family incomes before taxes of less than $15,000, 39 percent between $15,000 and $25,000, and 28 percent over $25,000. The vast majority (86 percent) were currently married. About half of the mothers (48

percent) were employed outside the home, a group about equally divided between those holding full-time and part-time jobs. Eighty-three percent of the sample were white, 11 percent black, 3 percent Latin American, and 3 percent Asian or American Indian.

In general, our respondents were fairly representative of the Lake County population in terms of range of social and economic characteristics, except to overrepresent minorities, high school graduates, and single-parent families.

Twenty-one percent of the children represented in the questionnaires were identified by their parents as mildly retarded, 34 percent as moderately retarded, 20 percent as severely and profoundly retarded, 12 percent as having cerebral palsy, 4 percent as autistic, and 9 percent as having epilepsy. Fifty-seven percent of the children were male and 43 percent were female.

Factor Analysis

Questionnaire items were developed as indicators of the conceptual framework summarized in Table 1. The items were factor analyzed using the principal factoring with iteration method and varimax orthogonal rotation. Items measuring community involvement and advocacy were analyzed for the entire sample, as were items measuring the stress experienced by mothers as a subset of the family career variables. A separate factor analysis for items assessing extended family support from grandparents was conducted only for the subsample of families with the children living at home in which at least one grandparent was living. Simple additive indexes were constructed on the basis of the patterning of variables identified by the factor analyses.

The variables used in this paper are explained in Appendix I. Table 2 lists the variables, and provides means and standard deviations for the total sample and each subsample.

Table 2 about here

## RESULTS

The analyses consist of a series of ordinary least squares regression analyses to evaluate the overall contribution of family demographics, family career, community involvement and advocacy, child's characteristics, and extended family to residential and vocational planning. Table 3 presents the intercorrelations for the variables used in the regression analyses for the total sample and the subsample of respondents with children at home and grandparents living.

Table 3 about here

The subsample was derived to test the hypotheses within that segment of the population where the family structure would be most likely to optimize the support assumed prerequisite to normalization. That is, family and community support variables, as they interact with the mentally retarded children's characteristics to explain parents' planning, can be assessed most effectively in those families where the children are living at home and other extended family (grandparents) are available. By the time this study was conducted in 1978, it was very difficult to place or maintain in an institutional setting any child except for the most severely disabled; the prognosis for such children achieving residential or voca-

tional autonomy in the future would be minimal. For those children living at home, the extended family is assumed to be a more effective socializing agency than the nuclear family. Selecting a subsample to examine intact families separately enables us to study the factors of interpersonal support as they relate to planning for normalized outcomes.

Family Demographics

Our hypotheses were based upon Farber's (1968:154, 197; 1975:259) prediction that the higher the socioeconomic status of families, the greater the emotional impact of a mentally retarded child would be. Families with higher socioeconomic status were assumed to hold higher expectations for children's performance and achievement, and therefore more likely to extrude children who could not meet these expectations. These bivariate predictions were supported (see Table 3). On the other hand, hypotheses derived from the prediction that intact extended families would be better able to cope with a mentally retarded member were generally not supported. Having grandparents alive was not significantly correlated with planning.

For the total sample (see Table 4), income and race--two of the three measures of socioeconomic status--were statistically significant in accounting for parents' planning, but in quite different ways. Higher income contributed to parents' planning for more restricted residential and vocational outcomes at the time of transition to adulthood at age 21. Whites were more likely than minorities to have made specific plans for future residential care. Whites seem less likely to envision a supportive family and community environment over their children's total life cycles, and higher family income seems to provide the means with which to plan for

protected adult environments. As expected, families whose children are living at home are less likely to project a residential future than are families with children already in residential care. What is surprising perhaps is the finding that the mentally retarded children's place of residence--at home or in an institutional setting--does not contribute to parents' assessment of appropriate work setting at age 21. This finding of no statistically significant association between place of residence and occupational planning does, however, validate the assumption underlying our sampling procedures, i.e., all the children in our sample are mentally retarded by physiological (and not merely cultural or social) criteria. They are not so-called "6-hour retarded" children, mentally retarded only by educational criteria (Mercer, 1973), who will leave school for regular jobs in the community.

Table 4 about here

In the subsequent subsample analysis, appropriate independent variables were introduced which were expected to account for parents' planning. When the subsample of children at home and grandparents alive (see Table 5) was analyzed, the selection variable CHATHOME was deleted and independent variables measuring child's characteristics were added, and the selection variable GPALIVE was deleted and independent variables measuring the kinds of extended family support were added. The addition of these variables seems to account for the influence of family income on parents' planning for sheltered work at age 21. However, higher family income continues to predict institutionalization at age 21 and whites continue to be more likely than minorities to plan for future residential care. Both findings

are consistent with Farber's predictions.

Table 5 about here

In general, demographic variables measuring socioeconomic status and family structure are not important predictors of parents' planning relative to interpersonal family and community support variables and child's characteristics.

Family Career

Birenbaum (1971) found that families' careers can be brought to a halt by the inability of mentally retarded members to assume age-appropriate roles in progressive stages. Therefore, we predicted that older parents and parents experiencing more stress were more likely to plan for restricted residential and vocational settings. The bivariate relationships predicted were supported (see Table 3).

In the regression analyses, both respondent's age and stress were statistically significant in accounting for parents' planning on all the dependent variables only for the total sample (see Table 4) before child's characteristics were taken into account. With child's characteristics entered into the regression equations for the subsample analyses, however (see Table 5), the relative importance of stress and age is quite different for residential planning than for vocational planning. Stress contributes to whether or not parents plan to institutionalize their children (to extrude them in Farber's [1968, 1975] phraseology). Age, but not stress, contributes to whether parents with children at home predict more restricted vocational settings at age 21. Age thus seems to be more a cross-sectional

measure of the historical effect of parents' beliefs about possible employment opportunities for mentally retarded adults than to be a measure of anxiety associated with aging as the current literature suggests (Baroff, 1974:23; Ayrault, 1971:165; Adams, 1972:115; Birenbaum and Seiffer, 1976:75).

Community Involvement and Advocacy

As described by Mechanic (1980:108, 110), personal and community supports are resources that families use to cope and to arrive at solutions about how to maintain family careers. Therefore we predicted that receiving advice from friends and political participation would exert a conservative influence on parents' planning. Conversely, perceiving the community as accepting of mentally retarded individuals and feeling excluded from parents groups were hypothesized to be associated with planning less restrictive residential and vocational outcomes. The bivariate relationships predicted were supported (see Table 3).

In the regression analyses, the perceived acceptance of mentally retarded individuals contributed to all dependent variables. Receiving advice from friends, political participation, and not feeling excluded from parents' groups contributed to planning more restricted residential settings only. Community involvement seems to provide an informational rather than a supportive therapeutic function to families with mentally retarded children. Participation in a community social network provides parents with information necessary to make decisions concerning their children's futures but not the support needed to achieve more normalized outcomes. This indicates that involvement in community networks, whether informally with friends or more formally through parents' groups or poli-

tical activities, is less important than perceived community acceptance in achieving less restrictive residential and vocational settings for mentally retarded adults.

Extended Family

Contrary to our predictions, when the bivariate correlations are examined (see Table 3) grandparents seem to exert a conservative influence whether they accept the mentally retarded child or support the parents. Grandparents do not seem to accept the children as "normal" as we had predicted, but to accept them as mentally retarded children who at an earlier point in their grandparents' lives would have been excluded from community activities and institutionalized.

When family, community and child variables are also controlled in the regression analyses (see Table 5), grandparents acceptance of the children and support for the parents are both associated with planning less restricted residential and vocational settings at age 21. In this sense, grandparents do seem to function as resources for families, enabling more normalized outcomes.

Children's Characteristics

As the literature suggests (Carver and Carver, 1972:53; Farber, 1968: 162; Mercer, 1966; Wing and Gold, 1979:106) the more severe the disability the more likely parents are to extrude mentally retarded children from their families. Farber (1968:157) found that mentally retarded males seem to create greater stresses for their families than do females. Birenbaum (1971:56) found that stress increases with child's age as discrepancies between age-appropriate behavioral expectations and actual performance

become greater. Hypotheses derived from these findings were generally supported by the bivariate correlations (see Table 3), except that families with mentally retarded daughters were more likely to plan restricted residential settings. It may be that families feel more protective of mentally retarded daughters than of sons.

In the regression analyses (see Table 5) families whose children have lower cognitive skills plan for more restricted vocational settings. Low cognitive skills do not affect residential planning whereas low social skills affect planning on all dependent variables. Apparently social disabilities are more important than cognitive disabilities in causing families to extrude their mentally retarded children.

Having mentally retarded daughters was a statistically significant predictor of parents' having made specific plans for residential care and parents' planning for more restricted vocational settings at age 21. This refutes Farber's (1968:157) finding that males create greater stress in families causing them to be extruded more often than females, but supports Bayley's (1973:154-157) finding that males tend to be employed in more normalized jobs in the community upon reaching adulthood.

Overall, the age of the mentally retarded child is the strongest contributor to predicting parents' planning for future residential and vocational settings. It is statistically significant (at the .01 level or less) for all planning variables. This finding strongly supports Birenbaum's (1971:56) finding that stress increases with the age of the mentally retarded children. Their inability to accept more responsibility in age-appropriate roles tends to halt family development through normative careers.[1]

## DISCUSSION

For families with mentally retarded children, the variables measuring family career and individual life cycle were among the strongest predictors of parents' planning for future residential and vocational services for their children (see Table 5). With increasing age mentally retarded children are unable to assume age-appropriate roles within the family (Birenbaum, 1971) and community. With increasing age, their parents become less able to care for their children's needs. As predicted by Farber's (1975) minimal adaptation theory, parents experiencing more stress plan for future residential services more than parents experiencing less stress. The elaboration of Farber's minimal adaptation theory to extended family members was supported. Extended family, as measured by grandparents' support, was found to contribute to parents' ability to cope with their mentally retarded children at home. Families with grandparents' support were less likely to have planned for restricted residential and vocational settings. It was hypothesized that community support, as measured by parents' involvement in formal and informal support groups, would help parents cope with their mentally retarded children at home. While community support variables were highly significant predictors, subsample analyses showed that community support tends to function as an informational resource rather than as a supportive therapeutic resource. Family demographics, usually the staples of social science research, were generally not associated with parents' future plans, especially in the subsample analyses as child's characteristics were entered into the regression equations.

Research findings support Farber's model that increased stress within the family caused by the presence of a severely mentally retarded child at home is associated with extrusion (in this study, planned extrusion) of the child from the home. These findings are the first empirical support of the minimal adaptation theory. What is significant is that the data suggest that the theory of minimal adaptation may be applicable to other more general theories, such as the theory of family careers espoused in this research.

Further subsample analyses show that it is not merely stress which explains planning behavior, but a host of other factors. Specifically, measures of individual life cycle and family career are strong predictors of parents' planning for future services supporting Birenbaum's findings. The age of the mentally retarded child is the single most important factor. Other characteristics of the child, such as social and cognitive skills, significantly predict parents' planning behavior. The findings that social disabilities are more important that cognitive disabilities in parents' planning behavior supports the literature (for example, Baller, Charles and Miller, 1967; Brolin, 1976; Cobb, 1972; Edgerton and Bercovici, 1976; and Katz, 1968) which found that social rather than physical impairments or deficits are more important in the adjustment of mentally retarded adults in the community. Families' involvement in personal and community support networks were statistically significant predictors of parents' planning for residential services. While family involvement in support networks seems to provide parents with needed information for residential placement rather than therapeutic support for maintaining the child at home, it is parents' perceptions of the community's acceptance of their

child which more strongly predicts parents' planning for both future residential and vocational settings.

The findings presented open an arena for more detailed research into the characteristics of families utilizing services for their mentally retarded children. It is suggested that further studies develop more sophisticated measurements of the interaction of the family career and individual life cycle concepts. One example would be investigating the impact of children's development on parents' individual life cycles at different family career stages. Rather than assuming normative childbearing patterns and adult development, such a design would account for variations in childbearing timetables of adults--that is, adults who have children either earlier, later, or on the same time schedule than current adult development theories propose (see Aldous, 1978).

Another caution for further research would be the need to study concurrently the family adaptations of parents with "normal" children and parents with children who have other disabilities (such as sick children [Burton, 1975; Travis, 1976], mentally ill children [Park and Shapiro, 1976; Shepherd, Oppenheim and Mitchell, 1966] and children with physical handicaps [McMichael, 1971; Ayrault, 1971]). It seems plausible that Farber's theory of family adaptation could be applied to all families who have children with chronically disabling conditions, not just families with severely mentally retarded children.

A hypothesis proposed, and not supported, that communities are entities that can provide therapeutic support for families should be challenged. Studies in social psychiatric epidemiology (see Levy and Rowitz, 1973) show that communities vary in the types of support they provide

their members. A more sophisticated measure of community support (perhaps involving service utilization data) is needed.

One explicit purpose of this study was to provide service providers and consumer groups with a carefully developed research base to use in planning services for mentally retarded adults. It is realized that planning in the early 1980's must take into consideration the current "tax-cutting" mood of the nation. Since present national priorities are focused on curbing government spending, increasing defense spending and developing domestic energy resources, human services in general are left trying to contend with constant or slightly rising expectations and constrained or reduced budgets.

Services to persons with mental retardation face budgetary cutbacks if not complete cancellation. "Mainstreaming" in school institutions and "deinstitutionalization" in residential institutions continue to be the policies implemented at local, state, and federal levels, though movement is afoot to end the federal mandate for tax-supported special education (P.L. 94-142). Planning for residential and vocational services for mentally retarded adults within the political climate should take into consideration parents' opinions and service choices.

Novak (1980) reports on several studies which show a backlash to the deinstitutionalization movement on the part of parents of mentally retarded children. The backlash against the deinstitutionalization and mainstreaming policies is coming from a small but significant group of parents whose children are more likely to have the severest disabilities. This should not be interpreted as an argument for ending the implementation of these policies, but a realization that the provision of a full

range of services is necessary to accommodate the broad range of persons who carry the label "mental retardation." Planners and consumer groups should also realize that the present push for the use of mutal aid self-help groups as alternatives to the public provision of public services could be disastrous. This study has shown that personal and community support networks (which include self-help groups for parents of mentally retarded children) provide informational, not therapeutic support. Therefore, the development of self-help groups should occur in tandem with, not instead of, the provision of a full range of services.

## FOOTNOTES

[1]Further regression analyses, not reported here, do show support for Birenbaum's finding of unfulfilled family careers. The analyses showed that, in general, parents of preschool (ages birth through five years) mentally retarded children are less likely to plan for restricted residential and vocational settings than parents of transition-age (ages nineteen to twenty-one years) mentally retarded young adults.

# APPENDIX I

## Detailed Explanation of Variables

### Residential and Vocational Planning (Dependent Variables)

RESFUTUR or residential future is respondents' planning for future residential care for their children. Responses were coded: (1) have not considered future residential care; (2) have considered the general idea; (3) have specific plans for residential care.

CH21RES is child's living situation perceived as appropriate at age 21. Responses were coded in terms of the amount of structured supervision provided in the living situations: (1) living on own or with friends; (2) with parent(s) at home; (3) supervised apartment house unit; (4) private residential facility; (5) a public residential facility.

CH21DO is child's work situation perceived as appropriate at age 21. Responses were coded in terms of the amount of structured supervision provided in the work situation: (1) regular job in the community; (2) a supervised job in a special business program (for example, in a hospital, restaurant or motel); (3) a job in a sheltered workship or a work activities program.

### Family Demographics

INCOMFAM or family income is the present (1978) yearly family income before taxes including dividends, interest, salaries, wages, pensions and all other income. Ten income categories were provided ranging from less than $2000 to $25,000 and over.

RESPRACE or respondent's race is a dummy variable set equal to 1 if the respondent is white, 0 if otherwise.

MYEDUC or mother's education is the level of formal schooling completed by the respondent measured in terms of seven categories ranging from elementary school or less to advanced postgraduate degree.

GPALIVE or grandparent alive is a dummy variable set equal to 1 if at least one of the child's grandparents is alive, and 0 if all are deceased.

MARSTAT or marital status is a dummy variable set equal to 1 if the respondent is currently married, 0 if otherwise.

CHATHOME or child at home is a dummy variable set equal to 1 if the mentally retarded child lives at home, 0 if otherwise.

Family Career

RESPAGE is respondent's age in years.

TENSEMOM or tension experienced by mother is an index which measures the amount of stress the respondent reports associated with the mentally retarded child. The value of TENSEMOM for each respondent is obtained by summing responses to three items covering the mother's reports of: becoming so frustrated by problems caused by the disability that she wished the child would die; feeling trapped at home because of the child; and wishing she could go out more without the child. The value of TENSEMOM was obtained by summing the scores from three Likert scale attitude questions, giving the index a range of 3 to 15.

Community Involvement and Advocacy

VERYOPEN or community acceptance is an index which measures perceived acceptance by neighbors of the respondent's mentally retarded child at different stages in life in the following situations: as a friend for

their own children of the same age; of the opposite sex; as a classmate at the same school; as a member of a social club; as a guest in their own homes; as a neighbor living in a community living facility upon reaching adulthood; and visiting respondent when child is at home. The value of VERYOPEN for each respondent is obtained by summing scores from seven Likert scale items, giving the index a range of 7 to 35.

FRADVICE or friends' advice is an index which measures frequency of consulting friends and family members for advice about the mentally retarded child. The value of FRADVICE for each respondent is obtained by summing scores to three Likert scale items: confiding in friends or relatives when worried; talking to other parents with mentally retarded children; and talking to other family members or friends when making a serious decision. The index has a range of 3 to 15.

PGEXCLUD or feeling excluded from parent groups is an index which measures respondents' reasons for not attending meetings with other parents of mentally retarded children: parents meetings are a waste of time because real decisions are made elsewhere; because they never seem to talk about things related to respondent's child; because people who run the meetings do not seem to care about the respondent; and because respondent does not feel comfortable with the kind of people who attend. The value of PGEXCLUD for each respondent is obtained by summing scores to four Likert scale items, giving the index a range of 4 to 20.

PROPOLIT or political participation is an index which measures involvement in two types of parent groups: governing or advisory board (dealing with the administration of an organization or facility for the mentally retarded), and a political advocacy group (working to expand op-

tions and services for the mentally retarded). The value of PROPOLIT for each respondent is obtained by summing scores on two 3-point questions, giving the index a range of 2 to 6. A score of 1 on each item indicates the respondent has not participated and does not plan to, 2 that the respondent has not participated but would like to, and 3 that the respondent has participated.

Child's Characteristics

LOCOGSKL or low cognitive skills is an index which measures the mentally retarded child's reported abilities in the following areas: reads simple sentences, writes simple sentences, and rides public transportation alone. The value of LOCOGSKL for each respondent with the child living at home is obtained by summing scores on the three Likert scale items, each ranging from "handles easily" to "child cannot do." The index has a range of 3 to 15.

LOSOCSKL or low social skills is an index which measures reported level of disabilities on twelve items: diagnosis as mild, moderate, severe, or profound; self-care activities (for example, goes to toilet without help, gets dressed, feeds self); understands when spoken to; speaks clearly enough to be understood; organizes activities for self (for example, turns on TV, picks up book or magazine, suggests playing a game); self-help skills (for example, shops, picks out right clothing for weather or event, prepares some meals, handles money); shakes hands when meeting someone for the first time; greets people by saying hello; eats properly; speaks at the proper volume; looks at people when spoken to; and knows how to behave properly in different settings. The index

LOSOCSKL has a range of 12 to 60 with a high score representing the lowest level of social skills.

CHILDSEX or sex of mentally retarded child is a dummy variable set equal to 1 if the child is male, 0 if female.

BIRTH or child's age is mentally retarded child's age in years.

Extended Family

GPCARING or grandparents' caring is an index which measures respondents' perception of the grandparents' acceptance of the mentally retarded child. The value of GPCARING for each respondent with at least one of the child's grandparents living is obtained by summing scores on two Likert scale items: grandparents do not see anything wrong with the child; and grandparent(s) would want the child to live with them if something happened to the parent(s). The index has a range from 2 to 10.

GPWARM or grandparents' warmth is an index which measures grandparents' perceived support of the parent(s). The value of GPWARM for each respondent with at least one of the child's grandparents living is obtained by summing scores on two Likert scale items: grandparents think respondent is handling the situation well; and respondent thinks contact with grandparents is less than it would be if the child was normal. The index has a range from 2 to 10.

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Table 1

Summary of Hypotheses About the Direction of the Predicted Associations Between Residential and Vocational Planning (Dependent Variables) and Family Demographics, Family Career, Community Involvement and Advocacy, Child's Characteristics, and Extended Family

| | Project Residential Future (RESFUTUR) | Project Institution-alization at Age 21 (CH21RES) | Project Sheltered Work at Age 21 (CH21DO) |
|---|---|---|---|
| **Family Demographics** | | | |
| Family Income (INCOMFAM) | + | + | + |
| Race, White (RESPRACE) | + | + | + |
| Mother's Education (MYEDUC) | + | + | + |
| Grandparent(s) Living (GPALIVE) | - | - | + |
| Currently Married (MARSTAT) | - | - | + |
| Child at Home (CHATHOME) | - | - | - |
| **Family Career** | | | |
| Mother's Age (RESPAGE) | + | + | + |
| Mother's Stress (TENSEMOM) | + | + | + |
| **Community Involvement and Advocacy** | | | |
| Community Acceptance (VERYOPEN) | - | - | - |
| Friends' Advice (FRADVICE) | + | + | + |
| Feeling Excluded (PGEXCLUD) | - | - | - |
| Political Participation (PROPOLIT) | + | + | + |
| **Child's Characteristics** | | | |
| Low Cognitive Skills (LOCOGSKL) | + | + | + |
| Low Social Skills (LOSOCSKL) | + | + | + |
| Child's Sex, Male (CHILDSEX) | + | + | - |
| Child's Age (BIRTH) | + | + | + |
| **Extended Family** | | | |
| Grandparents Accept Child (GPCARING) | - | - | - |
| Grandparents Support Parents (GPWARM) | + | + | + |

Table 2

Means and Standard Deviations of Variables

| | Entire Sample | | Respondents with Child at home and Grandparent(s) living | |
|---|---|---|---|---|
| | Mean | SD | Mean | SD |
| **Residential and Vocational Planning** | | | | |
| RESFUTUR | 1.81 | .80 | 1.68 | .71 |
| CH21RES | 2.61 | 1.29 | 2.38 | 1.18 |
| CH21DO | 2.31 | .85 | 2.21 | .87 |
| **Family Demographics** | | | | |
| INCOMFAM | 7.82 | 2.17 | 7.84 | 2.23 |
| RESPRACE | .85 | .36 | .85 | .36 |
| MYEDUC | 3.49 | 1.25 | 3.52 | 1.21 |
| GPALIVE | .85 | .36 | N. A. | N. A. |
| MARSTAT | .87 | .34 | .89 | .32 |
| CHATHOME | .88 | .32 | N. A. | N. A. |
| **Family Career** | | | | |
| RESPAGE | 39.02 | 9.42 | 36.92 | 8.54 |
| TENSEMOM | 6.03 | 2.88 | 5.81 | 2.80 |
| **Community Involvement and Advocacy** | | | | |
| VERYOPEN | 25.85 | 7.16 | 26.76 | 6.82 |
| FRADVICE | 9.53 | 2.39 | 9.58 | 2.27 |
| PGEXCLUD | 8.09 | 3.91 | 7.83 | 3.68 |
| PROPOLIT | 3.32 | 1.26 | 3.35 | 1.27 |
| **Child's Characteristics** | | | | |
| LOCOGSKL | N. A. | N. A. | 11.85 | 4.25 |
| LOSOCSKL | N. A. | N. A. | 29.07 | 11.97 |
| CHILDSEX | N. A. | N. A. | .58 | .49 |
| BIRTH | N. A. | N. A. | 10.39 | 5.77 |
| **Extended Family** | | | | |
| GPCARING | N. A. | N. A. | 6.61 | 2.91 |
| GPWARM | N. A. | N. A. | 8.91 | 1.59 |
| N . . . | 330 | | 248 | |

Note--N. A. = not applicable; variables explained in text.

Table 3

Correlations for Variables Used in Regression Analysis for all Respondents (Above Diagonal, N = 330); Respondents with Grandparent(s) Living and Children at Home (Below Diagonal, N = 248)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Residential and Vocational Planning** | | | | | | | | | | | | | | | | | | | | | |
| 1. RESFUTUR | — | .61 | .43 | .11 | .24 | .15 | .06 | .03 | -.53 | .16 | .37 | -.43 | .17 | -.08 | .09 | NA | NA | NA | NA | NA | NA |
| 2. CH21RES | .48 | — | .56 | .20 | .14 | .17 | .02 | .03 | -.50 | .19 | .43 | -.43 | .21 | -.10 | .19 | NA | NA | NA | NA | NA | NA |
| 3. CH21DO | .36 | .52 | — | .16 | .15 | .11 | -.06 | .04 | -.26 | .35 | .29 | -.46 | .17 | .05 | .11 | NA | NA | NA | NA | NA | NA |
| **Family Demographics** | | | | | | | | | | | | | | | | | | | | | |
| 4. INCOMFAM | .10 | .24 | .16 | — | .38 | .41 | .05 | .52 | -.06 | .14 | .12 | -.05 | .01 | -.04 | .06 | NA | NA | NA | NA | NA | NA |
| 5. RESPRACE | .24 | .12 | .09 | .37 | — | .27 | .03 | .35 | -.08 | .07 | .05 | -.05 | .11 | -.10 | -.02 | NA | NA | NA | NA | NA | NA |
| 6. MYEDUC | .19 | .20 | .10 | .43 | .28 | — | .12 | .16 | -.08 | -.01 | .15 | -.11 | .06 | -.08 | .13 | NA | NA | NA | NA | NA | NA |
| 7. GPALIVE | NA | NA | NA | NA | NA | NA | — | .08 | .03 | -.42 | .04 | -.01 | .07 | -.14 | .08 | NA | NA | NA | NA | NA | NA |
| 8. MARSTAT | .04 | .12 | .10 | .55 | .41 | .26 | NA | — | .05 | -.14 | .03 | -.001 | -.02 | -.05 | -.01 | NA | NA | NA | NA | NA | NA |
| 9. CHATHOME | NA | NA | NA | NA | NA | NA | NA | NA | — | .14 | -.25 | .35 | -.03 | .001 | -.04 | NA | NA | NA | NA | NA | NA |
| **Family Career** | | | | | | | | | | | | | | | | | | | | | |
| 10. RESPACE | .13 | .18 | .36 | .17 | .02 | .02 | NA | .19 | NA | — | .04 | -.14 | -.02 | .10 | .06 | NA | NA | NA | NA | NA | NA |
| 11. TENSEMOM | .31 | .40 | .28 | .16 | .06 | .19 | NA | .14 | NA | .15 | — | -.40 | .10 | .06 | .06 | NA | NA | NA | NA | NA | NA |
| **Community Involvement and Advocacy** | | | | | | | | | | | | | | | | | | | | | |
| 12. VERYOPEN | -.35 | -.39 | -.46 | -.09 | -.03 | -.11 | NA | -.05 | NA | -.14 | -.37 | — | -.07 | -.06 | -.13 | NA | NA | NA | NA | NA | NA |
| 13. FRADVICE | .23 | .25 | .13 | -.003 | .08 | .07 | NA | -.02 | NA | -.01 | .15 | -.10 | — | -.15 | .13 | NA | NA | NA | NA | NA | NA |
| 14. PGEXCLUD | -.08 | -.13 | .06 | -.09 | -.10 | -.06 | NA | -.03 | NA | .05 | .08 | -.09 | -.14 | — | -.15 | NA | NA | NA | NA | NA | NA |
| 15. PROPOLIT | .08 | .24 | .12 | .06 | -.02 | .10 | NA | .04 | NA | .07 | .08 | -.14 | .10 | -.10 | — | NA | NA | NA | NA | NA | NA |
| **Child's Characteristics** | | | | | | | | | | | | | | | | | | | | | |
| 16. LOCOCSKL | .18 | .19 | .23 | .14 | .28 | .26 | NA | .10 | NA | -.19 | .15 | -.19 | .18 | -.15 | .06 | — | NA | NA | NA | NA | NA |
| 17. LOSOCSKL | .14 | .17 | .14 | -.02 | .07 | .16 | NA | -.04 | NA | -.42 | .19 | -.25 | .10 | -.01 | -.05 | .54 | — | NA | NA | NA | NA |
| 18. CHILDSEX | -.14 | -.02 | -.07 | .09 | -.13 | .03 | NA | .03 | NA | -.04 | -.01 | -.11 | -.02 | .06 | .07 | .004 | .02 | — | NA | NA | NA |
| 19. BIRTH | -.11 | -.16 | -.27 | -.08 | .09 | .20 | NA | -.03 | NA | -.62 | -.02 | .18 | .12 | -.13 | -.07 | .46 | .52 | .003 | — | NA | NA |
| **Extended Family** | | | | | | | | | | | | | | | | | | | | | |
| 20. GPCARINC | .04 | .20 | .07 | -.13 | -.16 | -.08 | NA | -.07 | NA | .09 | .24 | -.21 | -.11 | .23 | .03 | -.09 | .05 | -.03 | .06 | — | NA |
| 21. GPVARM | .18 | .35 | .44 | .14 | .02 | .12 | NA | .10 | NA | .28 | .29 | -.42 | .05 | .02 | .13 | .20 | .10 | -.04 | .12 | -.20 | — |

NOTE—NA = Not applicable; variables explained in text.

Table 4

Regression Analysis of Family and Community Variables on Residential and Vocational Planning for Total Sample (Reported coefficients are Beta weights, N=330)

| | RESFUTUR | CH21RES | CH21DO |
|---|---|---|---|
| **Family Demographics** | | | |
| INCOMFAM | -.01 | .13** | .10* |
| RESPRACE | .18*** | .03 | .08 |
| MYEDUC | .01 | .01 | -.01 |
| GPALIVE | .09* | .03 | .05 |
| MARSTAT | -.04 | -.06 | -.07 |
| CHATHOME | -.39*** | -.34*** | -.06 |
| **Family Career** | | | |
| RESPAGE | .11** | .11** | .30*** |
| TENSEMOM | .17*** | .24*** | .10* |
| **Community Involvement and Advocacy** | | | |
| VERYOPEN | -.19*** | -.17*** | -.33*** |
| FRADVICE | .09* | .13** | .13** |
| PGEXCLUD | -.07 | -.09* | .03 |
| PROPOLIT | .005 | .09* | .02 |
| $R^2$ = | .44 | .45 | .35 |

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 5

Regression Analysis of Family, Community and Child Variables on Residential and Vocational Planning for Respondents with Children at Home and Grandparents Living (Reported Coefficients are Beta Weights, N=248).

| | RESFUTUR | CH21RES | CH21DO |
|---|---|---|---|
| **Family Demographics** | | | |
| INCOMFAM | -.04 | .14* | .05 |
| RESPRACE | .20** | .03 | .004 |
| MYEDUC | .12* | .07 | -.01 |
| MARSTAT | -.10 | -.04 | -.02 |
| **Family Career** | | | |
| RESPAGE | .03 | -.01 | .22*** |
| TENSEMOM | .17** | .19*** | .04 |
| **Community Involvement and Advocacy** | | | |
| VERYOPEN | -.22*** | -.09 | -.22*** |
| FRADVICE | .15** | .19*** | .07 |
| PGEXCLUD | -.08 | -.16** | .05 |
| PROPOLIT | .01 | .15** | .03 |
| **Child's Characteristics** | | | |
| LOCOGSKL | .05 | .05 | .19** |
| LOSOCSKL | .10 | .18** | .17** |
| CHILDSEX | -.13** | -.03 | -.09* |
| BIRTH | .21** | .28*** | .25*** |
| **Extended Family** | | | |
| GPCARING | .04 | -.11* | -.18*** |
| GPWARM | -.005 | -.17*** | .05 |
| $R^2$ = | .30 | .42 | .42 |

* $p < .05$; ** $p < .01$; *** $p < .001$